

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/25/2015
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NAME OF PROVIDER OR SUPPLIER MARIGOLD REHABILITATION HCC	STREET ADDRESS, CITY, STATE, ZIP CODE 275 EAST CARL SANDBURG DRIVE GALESBURG, IL 61401
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S 000	Initial Comments Complaint #1524489/IL79470	S 000		
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)6) 300.2420j) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures	S9999		

Attachment A
Statement of Licensure Violations

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/14/15

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S9999	Continued From page 1 shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents Section 300.2420 Equipment and Supplies j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars and reciprocal pulleys. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These requirements were not met as evidenced by: Based on interview and record review, facility staff failed to address a known mechanical failure with the facility van lift, failed to follow the facility van driver protocol and report it to the administrator and failed to follow the manufacturer's recommendations for servicing the wheelchair van lift, all of which had the	S9999		

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S9999	Continued From page 2 potential to affect 10 residents (R1 to R9 and R11) reviewed for safety in the sample of 10 who use the small van for transportation needs. These failures also resulted in R1 falling from the van lift, sustaining a head injury which resulted in death. FINDINGS INCLUDE: The Operator's Manual for the facility's wheelchair van lift, dated (revised October 2006) includes the following information: "Operation Notes and Details-Warning! Discontinue lift use immediately if any lift component does not operate properly. Failure to do so may result in serious bodily injury and/or property damage. Outer Barrier: This spring-loaded roll stop provides a ramp for wheelchair loading and unloading at ground level. When the platform lowers fully to ground level, the roll stop activation feet automatically unfold (rotate) the barrier to the ramp position (fully loaded). Although the outer barrier is lift-powered, the activation of the barrier is controlled by the lift operator (attendant). Pressing the DOWN switch unfolds the barrier. The outer barrier is spring-loaded to automatically fold (rotate) to the vertical position when the UP switch is pressed. As the activation feet lift off the ground, the torsion springs rotate the barrier to the vertical position. Discontinue lift operation immediately if the barrier does not operate properly. Maintenance and Lubrication: Proper maintenance is necessary to ensure safe, troublefree operation. Inspecting the lift for any wear, damage or other abnormal conditions should be a part of all transit agencies's daily service program. Simple inspections can detect potential problems. The maintenance and lubrication procedures specified in the following schedule must be performed by a (manufacturer)	S9999			

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S9999	<p>Continued From page 3</p> <p>authorized service representative at the scheduled intervals according to the number of cycles. All listed inspection, lubrication and maintenance procedures should be repeated at '750 cycle' intervals following the scheduled '4500 Cycles' maintenance. These intervals are a general guideline for scheduling maintenance procedures and will vary according to use and conditions. Lifts exposed to severe conditions (weather, environment, contamination, heavy usage, ect.) may require inspection and maintenance procedures to be performed more often than specified."</p> <p>A facility incident report dated 8/15/15 sent to the State Agency regional office indicates that R1 fell off the wheelchair lift of the facility van at 10 AM while at the local hospital where R1 had a dialysis appointment. The report states that while the Certified Nurses Assistant (CNA) was locking R1 's wheelchair on the lift, the " bar on the lift bumped into (R1 's) wheelchair. " The report indicates that R1 then fell off the lift, was taken to the local hospital 's emergency department, and then later transferred from there to a hospital trauma center out of town.</p> <p>A facility document sent to the State Agency regional office on 8/20/15, signed by the Administrator (E1) and entitled " Follow up report to event of 8/15/15 " states under the " Description of Event " section: " Resident (R1) was transported to dialysis center per facility van. The resident was being transported in a wheelchair. The transportation CNA placed the resident on the wheelchair lift and had locked one of the wheelchair wheels. As so sic (she) was attempting to lock the other wheelchair wheel, the lift malfunctioned and the flap that prevents the wheelchair from rolling off released. The wheelchair rolled off the lift and resident (R1) fell.</p>	S9999			

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S9999	Continued From page 4 Head injury resulted from the fall. The transportation CNA immediately called 911. (Paramedics) arrived and resident was transported to the hospital. " This document states under the " Investigation of Events " section: " Facility van was immediately removed from service for review and remains out of service. " The document states under the " Conclusion " section: " At this time it is felt that the resident fall resulted due to equipment failure. " R1's Physicians Order Sheet, dated August 2015 include the following diagnoses: Diabetes Mellitus, End Stage Renal Disease, Chronic Kidney Disease and Diabetic Retinopathy. R1's current care plan, dated 01/23/15 includes the following problems: Dialysis for chronic renal failure. Dialysis schedule three times a week. Facility transports to dialysis. On 08/20/15 at 9:05 A.M., E3 (Certified Nursing Assistant) CNA stated, "On Saturday (August 15, 2015), around 9:30 (in the morning) I loaded R1 first, then R2 into the little van. I opened the back doors, unfolded the lift and lowered the lift with a button. Every once in awhile the button sticks and you have to keep pushing it to release it to lower it to the ground. I got both loaded and went to the dialysis at (the local hospital). I opened the back door, unfolded the lift, went in the side door to check (R2). I lowered (R2) down, the lift worked fine. I got (R2) off the lift and onto the sidewalk. I raised the lift back up. There is a flap on the end of the lift that is supposed to be up when you take the lift up. It stayed down and I pushed it back up, with my hand. I unstrapped the seat belt and the straps on the floor. I pushed (R1) onto the lift. I locked (R1)'s wheelchair brake. Every once in awhile, the lift will jerk. It jerked and the flap fell	S9999		

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S9999	<p>Continued From page 5</p> <p>down and (R1)'s (wheel) chair fell backwards. That is about two feet. (R1) fell and hit the back of (R1)'s head. I had my cell phone on me, so I called 911. There is a covering over the wires and sometimes (other) transporters don't cover it. I always try to make sure it is covered. It has stuck on me probably three times. I have told (E6 Transportation Coordinator) and (E5 Maintenance Director) . (E5) has tried to fix it, but it eventually breaks again."</p> <p>On 08/20/15 at 10:45 A.M., E4 (Alzheimer's Coordinator) stated, "Saturday August eighth was the last time I drove the (facility) van. Lately, I drive the van one to two times a month. Every now and then the button sticks and the lift kind of jumps. It has been going on for a couple of months. I have told (E5 Maintenance Director) about it, and (E6 Transportation Coordinator) . (E5) fixes things on it. (E5) tries."</p> <p>On 08/20/15 at 11:05 A.M., E5 (Maintenance Director) stated, "On the little van, I have worked on the lift. I am not certified or have additional training from the lift company to work on the lift. Some of the springs weren't functioning, I replaced them. The last time I worked on the lift was two to three months ago. We changed the controller on that van about a year ago. The actual control box had to be fixed. There is a problem with the computer that operates the lift. (E6 Transportation Coordinator) and E3 (Certified Nursing Assistant) told me about it, this past week. I don't write things down when someone tells me things are broke. I keep it in my head."</p> <p>On 08/20/15 at 11:20 A.M., E6 (Transportation Coordinator) stated, " I drove it (the van) to the corporate office and the corporate van person looked at it. We unfolded the lift and lowered it to</p>	S9999		

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S9999	<p>Continued From page 6</p> <p>the ground, but when we raised it back up, we noticed the flap did not go up. The spring was broke. You could see it."</p> <p>On 8/20/2015 at 12 noon, E8 (CNA) stated, " It has been approximately two weeks, around August 11th, since I have driven the facility van to transfer residents. The flap on the lift has not been working properly, the flap on the lift does not properly go up when the lift goes up. I have to look to see that the flap has gone up. If flap does not go up, I manually lift the flap up and flap will click in place. I do not drive the van on a daily basis so, I did not report the malfunction of the lift. When I drove the van last I manually put the flap up myself with my hands, it has been at least two weeks since it has not been working correctly."</p> <p>On 8/20/2015 at 2:45 PM E1 (Administrator) stated "I received a call from E3 (CNA) (Certified Nurses Aide) regarding the 8/15/2015 incident with R1 and the malfunction of the van lift. E3 stated, "I got R2 off the van first and placed him under the canopy the transfer went fine. R1 then was placed on lift, then I locked one brake on wheelchair, then went to lock second brake on wheelchair and the back of the lift (flap) had fallen down and wheelchair had rolled out with R1 falling to ground hitting the back of her head."</p> <p>E1 stated," No, I am not aware of any malfunctions in the past or currently, I have not been made aware of any problems with the flap on the lift, nor am I aware that the drivers knew the flap was broken."</p> <p>A list dated 8/25/15 provided by E6 of residents who are in wheelchairs and use the facility van for transportation listed residents R1 to R9 and R11.</p>	S9999	0		

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S9999	Continued From page 7 On 08/20/15 at 8:30 A.M. R2 stated, " I have been here since 2012. I go to dialysis three times a week. I am transported via facility van." In regards to the incident on 08/15/15, "I had been taken off of the van. I was on the ground, under the canopy. I saw (R1) being pushed by (E3 Certified Nursing Assistant) onto the lift. I saw (R1) fall and hit (R1)'s head. The wiring in the van is faulty. It's over-used. Every time you push the button on the lift, you have to keep pushing the button. That has been broke for three years. Everybody knows it's broke. The administrator (E1) knows about it. They can't afford to fix it. When they push the button, it jerks you back up to the starting position. Every time something happens with the van, they borrow a van from somewhere else. When they bring it back, it still doesn't work right. It's always broke. we were riding in it one day and it caught on fire, not that long ago. Supposedly they fixed it, but it's not. It's still broke. On 08/20/15 at 9:30 A.M., R3 stated, "I go to dialysis three days a week. I usually go by the facility van, in my wheel chair. There is one lady that drives the van, that scares me. She says she doesn't do it very often and you can tell. She is very unsure of herself. I don't feel safe when she is driving. I know the button on the controller sticks at times and the lift jerks you." On 08/20/15 at 10:30 A.M., R5 stated, "I go to the doctors to get treatments. I ride in the van in my wheel chair. Something is wrong with the button on the lift, it jerks. It causes you to jump." On 8/20/2015 at 10:40 A.M. R6 stated, " I don't like the van, if I am in pain the van is bad and rickety, it shakes too much causes me more pain.	S9999			

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S9999	Continued From page 8 And there is problems with the lift, it goes up and I am in the wheelchair it gets stuck in the air, they do something to the " button" makes it go up the rest of there way or down. Sometimes I do get scared of riding the van." E5 (Maintenance Supervisor) stated on 8/22/15 at 9:07 AM that the wheelchair lift for the small facility van used for transporting residents to medical appointments has experienced mechanical problems since the facility received the van from a sister facility about two years ago. E5 said that approximately one year ago, the lift had electronic problems in which the lift would stop on the way down. E5 said that the lift was repaired at the lift service company at that time. E5 said that two to three months ago, the lift ' s platform barrier flap, which is supposed to flip up in a vertical position as the platform is raised off the ground, moved up slowly and did not lock into place as quick as normal. E5 said that he replaced a spring on the barrier flap at that time, and it worked normally after that. E5 stated that the purpose of the barrier flap on the platform is to prevent a patient ' s wheelchair from rolling off the lift when the platform is raised off the ground. E5 stated that about one to two weeks ago, a facility van driver (whom he could not recall) informed him that the lift ' s barrier flap was not raising up into the vertical position as it normally does, but moved up slowly. E5 said that he did not work on the lift or send the lift to the lift service company at that time. E5 said that he told the van drivers at that time to " bump it (barrier flap) back up. " E5 stated that E6 (Transportation Coordinator) inspects the two facility vans once monthly using the Van Safety Checklist, but that the checklist	S9999			

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S9999	<p>Continued From page 9</p> <p>does not address an inspection of the van ' s lift. E5 stated that the facility vans are inspected twice a year for the State required vehicle safety check, but that this inspection does not include an inspection of the lift. E5 said that it has been approximately one year since the van lift was serviced at lift service company.</p> <p>E3 clarified on 8/22/15 at 9:45 AM that when E3 rolled R1 onto the lift platform at the back of the van last Saturday, R1 was facing towards E3. E3 said that E3 locked the right brake on R1 ' s wheelchair, and as E3 was reaching in front of R1 to lock the left brake on the wheelchair, the lift platform " jerked, " causing the platform barrier flap to fall down. E3 said that R1 and her wheelchair then started to roll backwards. E3 said that E3 tried to grab the front of the wheelchair, but it had happened too fast, and R1 was already rolling off the platform.</p> <p>E6 stated on 8/22/15 at 10:35 AM that E6 or E5 do a monthly inspection of the two facility vans, and that E6 checks the lifts on the vans as well. E6 said that there is no place though on the monthly van inspection sheets to document this. E6 also said that there is no other document to note E6 ' s lift inspection either.</p> <p>On 08/24/15 at 8:50 A.M., Z1 (Service Technician for the facility's van lift) stated, "I have further training on van lifts through (the van lift manufacturer). E9 (Corporate Information Technologist) dropped this van off last Monday (08/17/15). (E9) said it had been involved in an incident. When I checked the lift over, I noticed on the barrier flap, one of the feet that releases and holds it in place when it is going up and down, was missing. It was laying on the floor of the van."</p> <p>On 08/24/15 at 10:05 A.M., Z2 (Customer Experience Manager for van lift manufacturer)</p>	S9999			

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S9999	<p>Continued From page 10</p> <p>stated, "(This) series lift is a commercial grade lift that have been certified by the National Highway Transportation Safety Association. The roll stop latch at the end of the lift is a safety mechanism to prevent unintended wheel chair roll-away."</p> <p>On 08/24/15 at 11:10 A.M., Z3 (R1's son) stated, "Right after (R1) was transferred to (Trauma Center), (R1) was still conscious and able to hold a conversation. (R1) said one of (R1)'s wheel chair brakes was locked and then (R1) felt something jerk and somehow (R1) rolled off of the lift. (R1) also said the stop at the end of the lift was broken for sometime."</p> <p>On 08/20/15, E6 (Transportation Coordinator) provided a list of facility approved van drivers. Included in the list are E3 (CNA), E4 (Alzheimer's Director), E5 (Maintenance Director), E6 (Transportation Coordinator), E7 (Activity Director) and E8, E10 and E11 (all CNAs).</p> <p>The facility form, titled "Mandatory Van Safety Demonstration In-service" dated 06/01/15 and signed by E3, E4, E5, E6, E7, E8, E10 and E11 includes the following statement, "Employee understands that it is their responsibility to report any maintenance concerns with the (company) van to their Administrator immediately."</p> <p>The facility form, titled "Van Safety Checklist" dated monthly from 01/09/15 through 08/03/15 and signed by E6 (Transportation Coordinator) includes the following areas that are inspected: seat belts, lights, glass, heater/defroster, windshield wipers, steering, horn, brakes, parking brake, muffler, tires, oil change and transmission/differential.</p> <p>On 08/20/15 at 11:20 A.M., E6 (Transportation</p>	S9999			

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S9999	<p>Continued From page 11</p> <p>Coordinator) stated, "We do a monthly inspection on the van that is documented. Either myself or (E5 Maintenance Director) does the inspection. (E1 Administrator) keeps the documentation of those inspections. The van safety checklist does not include checking the lift."</p> <p>An invoice, dated 05/07/14 for the 2006 facility van includes the following information, "Replaced the broken magnets on the outer barrier latch."</p> <p>An invoice, dated 11/25/14 for the 2006 facility van includes the following information, "The lift was disassembled when it was brought in for service. The lift would keep going up and fold itself in when the button was pressed."</p> <p>An invoice, dated 08/17/15 for the 2006 facility van includes the following information: "Lift involved in accident. Foot missing on drivers side, outer barrier latch."</p> <p>R1's Emergency Room Report, dated 08/15/15 includes the following Brain Computerized Tomography report," Impression: Right Frontal and Interhemispheric Subdural Hematoma. Interhemispheric Subarachnoid Hemorrhage. Mild Leftward 4 MM (millimeter) Midline Shift." and the following Disposition, "Transfer ordered to (Regional Trauma Hospital) for higher level of care."</p> <p>R1's trauma center hospital discharge summary dated 8/19/2015 at 11:29 AM authored by Z4 (trauma center hospital APN/Advanced Practice Nurse) states the following under the "Hospital Course" section: "(R1) was initially admitted after fall with SDH (Subdural hematoma), SAH (Subarachnoid hemorrhage). She lives in a nursing home and was</p>	S9999			

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6005797	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 08/25/2015
NAME OF PROVIDER OR SUPPLIER MARIGOLD REHABILITATION HCC		STREET ADDRESS, CITY, STATE, ZIP CODE 275 EAST CARL SANDBURG DRIVE GALESBURG, IL 61401		
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S9999	<p>Continued From page 12</p> <p>in her normal state of health and was getting ready to be transported to dialysis. She was in her wheelchair in a lift being transported onto the van when the back bar of the lift broke. Her wheelchair fell off of the lift from its highest point and she fell backwards. She hit the back of her head. The people present report no loss of consciousness. She was transported to (the local hospital) where the head CT showed a small frontal SDH and interhemispheric SDH. Neurosurgery did not recommend any surgical interventions at that time. She appeared to be at her baseline mental status immediately after the fall. Her mental status acutely declined the morning of August 16th, with acutely worsening left sided weakness and right sided gaze. Repeat head CT showed minimal shift to the left and increasing hemorrhage. She was transferred to the ICU (Intensive Care Unit) and did have an ileus that was being managed by the surgeons via NG (Nasogastric) tube for bowel rest. However, she continued to neurologically decline over the 18th. She progressively required more oxygen support over the 18th. Son was called and discussed the progression of his mother's care. He changed her code status back to her previous one of DNR comfort, but not active comfort measures. Over the night of the 18-19th she continued to decline and then goals were changed to comfort measures only. She expired at 1040 (AM)."</p> <p>Z4 (trauma hospital APN/Advanced Practice Nurse) confirmed on 8/27/15 at 9:10 AM that R1's death was directly related to the recent fall and resulting brain injury.</p> <p>(AA)</p>	S9999		

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Marigold Rehabilitation and Health Care Center

DATE AND TYPE OF SURVEY: August 25, 2015, Complaint# 1524489/IL79470

300.610a)

300.1210b)

300.1210d)6)

300.2420j)

300.3240a)

Attachment B Imposed Plan of Correction

Section 300.610 Resident Care Policies

a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents

Section 300.2420 Equipment and Supplies

j) There shall be a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures. This shall include at a minimum the following: wheelchairs with brakes, walkers, metal bedside rails, bedpans, urinals, emesis basins, wash basins, footstools, metal commodes, over the lap tables, foot cradles, footboards, under the mattress bed boards, trapeze frames, transfer boards, parallel bars and reciprocal pulleys.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident*

IMPOSED PLAN OF CORRECTION

NAME OF FACILITY: Marigold Rehabilitation and Health Care Center

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This will be accomplished by:

- I. A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding accident hazards/assistance devices/adequate nursing supervision. This review will ensure that the facility's policies and procedures address, at a minimum, the following:
 - A. Recognition of situations that could lead to resident injury and/or death.
 - B. Appropriate reporting procedures for staff.
 - C. Appropriate and thorough investigations and follow-ups of accident hazards, inadequate assistance devices and supervision.
 - D. The facility's responsibilities to prevent further potential abuse and or neglect while the investigation is in progress.
 - E. The facility taking appropriate corrective action when an alleged violation is verified.
- II. The facility will conduct MANDATORY in-services for all staff within 30 days that addresses, at a minimum, the following:
 - A. Any new or revised policies and procedures, including actions needed to follow them that are developed as a result of this Plan of Correction.
 - B. All staff will be informed of their specific responsibilities and accountability for the care provided to residents.
 - C. Documentation of these In-Services will include the names of those attending, topics covered, location, day, and time. This documentation will be maintained in the Administrator's office.
- III. The following actions will be taken to prevent re-occurrence.
 - A. The above In-Service Education will be reviewed with all staff on a regular basis.
 - B. Supervisory staff will ensure that the State Regulations regarding environmental hazards (reporting and follow-up) are followed.
 - C. Supervisory staff will ensure that staffs are informed of the level of care required for each resident to whom they are assigned.
 - D. Supervisory staff will ensure there is a sufficient quantity of resident care equipment of satisfactory design and in good condition to carry out established resident care procedures.
- IV. A Committee consisting of, at a minimum, the Medical Director, Administrator, and Director of Nursing (DON) will review and revise the policies and procedures regarding abuse, and neglect. This review will ensure that the facility's policies and procedures address, at a minimum, the following:
 - A. Monitor items 1 through 3 to ensure compliance with this Imposed Plan of Correction.

COMPLETION DATE: Seven (7) days from receipt of the Imposed Plan of Correction.

JB/Marigold Rehabilitation and HCC 10-07-2015